

EAR NOSE & THROAT MEDICAL CENTER

Patient Information:

Name _____ Date of Birth _____
First Middle Initial Last

MEDICAL HISTORY:

Are you allergic to any medication? Yes No Please List: _____

Are you currently taking any medication? Yes No Please List: _____

PAST SURGICAL HISTORY:

Have you had any surgical procedures? Yes No Please List: _____

Are you pregnant? Yes No How Many Months? _____ Breast-feeding? Yes No

Have you taken a cortisone drug recently? Yes No For what? _____

SOCIAL HISTORY: DO YOU...

Use Herbal Products? Yes No Please List: _____

Exercise Regularly? Yes No Use Alcohol? Yes No Ever used Tobacco? Yes No
Type: _____ Beer/Wine/Liquor Cigarettes/Cigars/Pipe/Snuff/Chew Tobacco
How often? _____ How often? _____ How often? _____
Date Stopped: _____

PATIENT MEDICAL HISTORY: Have you ever had or still have (Check for Yes):

- | | | | |
|-----------------------------------------------|-----------------------------------------------|--------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Sickle-Cell Disease |
| <input type="checkbox"/> Allergy Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Disorders | <input type="checkbox"/> Sjogren's Syndrome |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis History | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> HIV | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Reflux Problems | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Cholesterol Problems | <input type="checkbox"/> Liver Problems | | |

FAMILY HISTORY: Have any blood relatives had:

- | | | |
|--------------------------------------------|----------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |

Who is legal custodian of minor? _____ Relationship to minor? _____

Signature: _____ Date: _____